AUTHORIZATION FORM FOR DISCLOSURE AND USE OF PERSONAL PROTECTED HEALTH INFORMATION

I, _____, (Plan Member), Social Security No. _____, at my request, authorize State Employee Benefits Personnel, including legal counsel and Business Associate Medical & Claims Personnel, to request, receive & review copies of the following: CHECK ALL THAT APPLY.

A. ____My medical/treatment records from the following listed providers:

Please state the name, address and telephone number of the Provider and the time period for which the records are being requested. Please be as specific as possible. If the records are for treatment of a specific illness only, please state the illness so that only those records will be released:

_____
_____
_____
_____

NOTE: Psychotherapy notes. The above information must be filled out as a separate single specific release for psychotherapy notes for a specific period and stated specific purpose written in above.

B. ____My billing records from the following listed providers:

Please state the name, address and telephone number of the Provider and the time period for which the records are being requested. (If applicable, you may skip details and simply state same as A above)**:**

_____
_____
_____

C. ____The above records are released solely to determine eligibility for membership.

- **IF EITHER OR BOTH BOXES A OR B ARE CHECKED THE PURPOSE OF THIS RELEASE IS SOLELY TO REVIEW QUESTIONED CLAIMS AND TREATMENT.**
- **REFUSAL TO SIGN THE NECESSARY AUTHORIZATION MAY PREVENT THE PLAN FROM RECEIVING THE INFORMATION IT NEEDS TO POTENTIALLY ADJUST BENEFITS.**
- **THIS AUTHORIZATION IS VALID FOR A PERIOD OF 12 CALENDAR MONTHS FROM THE DATE OF SIGNING. (SEE THE PRIVACY NOTICE GIVEN OUT BY THE PLAN.)**
- **IF BOX C IS ALSO CHECKED THIS RELEASE IS FOR ELIGIBILITY ONLY AND IT REMAINS IN EFFECT AS LONG AS YOU ARE A PLAN MEMBER.**
- ***YOU MAY REVOKE THIS RELEASE IN WRITING AT ANYTIME PRIOR TO THE RECORDS BEING RECEIVED.*** ***PLAN MEMBER MUST BE GIVEN A SIGNED COPY OF THIS AUTHORIZATION. THIS FORM IS AVAILABLE ON THE WEB.**

DATED: _____ **_____**

Plan Member's Signature

****_____**

(If this authorization is signed by a court ordered legal representative or parent of an unemancipated minor please note your authorized title under the signature line.)**